

HOLD FOR FIRST AMERICAN TITLE

FA-19375

Property Address: 8650 Beech
Munster, In 46321

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

Lois V. Seliger, Affiant, states that:

1. Warren D. Seliger, deceased, died on the 6 day of FEBRUARY, 1989;

2. Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;

4. The deceased and Affiant were married on the 20 day of SEPTEMBER, 1947; and were never divorced.
(This item applies only to the surviving spouse.)

5. All expenses of the last illness and funeral of the deceased have been paid;

6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

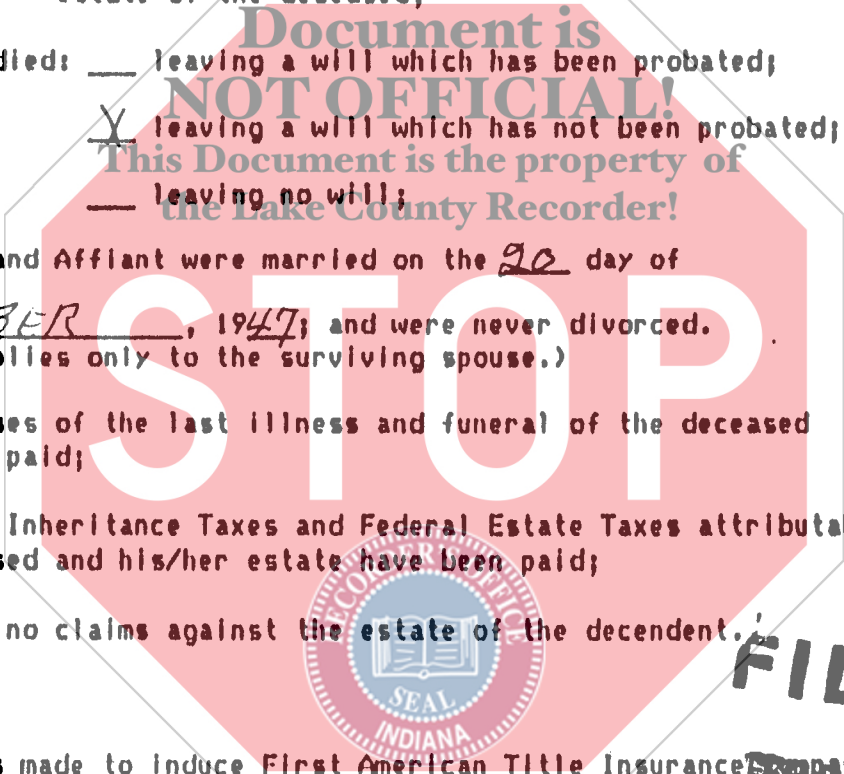
7. There are no claims against the estate of the decedent.

97007065

97FEB-5 AMID:LS

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

MORRIS W. CARTER
RECORDER



FILED

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

1-30-97
Date

Lois V. Seliger
Signature of Affiant

LOIS V. SELIGER
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 30th day of January, 1997.

Melissas B. Lesch
Printed Name of Notary

Melissa B. Lesch
Signature of Notary

My Commission expires: 11-24-00

My County of Residence is: Lake

000142

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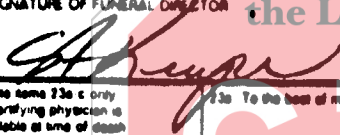
INDIANA STATE BOARD OF HEALTH CERTIFICATE OF DEATH

Local No. 54

State No.

HOLD FOR FIRST AMERICAN TITLE

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Marvin G Seliger		2 SEX M	3 DATE OF DEATH (Month Day Year) February 6, 1989
4 SOCIAL SECURITY NUMBER 359-16-0409	5a AGE—Last Birthday (Year) 64	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	7 PLACE OF DEATH (Check one and fill in parentheses) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
8 FACILITY NAME (If not institution give street and number) St. Catherine Hospital		9 CITY TOWN OR LOCATION OF DEATH East Chicago	10 COUNTY OF DEATH Lake
11 MARRITAL STATUS—Married Never Married Widowed Divorced (Specify) Married	12 SURVIVING SPOUSE (If wife give maiden name) Lois Hacker	13 DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life (Do not use retired)) Pattern Maker	14 KIND OF BUSINESS/INDUSTRY Pattern Works
15a RESIDENCE—STATE Indiana	15b COUNTY Lake	15c CITY TOWN OR LOCATION Munster	15d STREET AND NUMBER 8650 Beech
16a INSIDE CITY LIMITS? (Yes or no) Yes	16b ZIP CODE 46321	16c WAS DECEASED OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban Mexican Puerto Rican etc.) No	16d RACE—American Indian Black White etc. (Specify) White
17 FATHER'S NAME (First Middle Last) Charles Seliger		18 MOTHER'S NAME (First Middle Maiden Surname) Elsie Perz	
19a INFORMANT'S NAME (Type/Print) Lois Seliger		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8650 Beech Munster, Indiana	19c Relationship Wife
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) February 9, 1989 Calumet Park Cemetery	20c LOCATION—City or Town, State Merrillville, Ind.
21a SIGNATURE OF FUNERAL DIRECTOR 		21b LICENSE NUMBER (of Licensee) FDG 1014511	21c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Highland, In. FDH 300-
22a TIME OF DEATH 2:22 P.M.		22b DATE PRONOUNCED DEAD (Month Day Year) February 6, 1989	22c WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) NO
23 PART I Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) SMALLPOX DUE TO (OR AS A CONSEQUENCE OF) ONKNO SCHEDULED VAXINE ONLINE DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or injury that initiated events resulting in death) LAST PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		24 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Mths.	
25a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place listed and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.		26a WAS AN AUTOPSY PERFORMED? (Yes or no) NO	
27a SIGNATURE AND TITLE OF CERTIFIER Anton V. Mumbay, MD		27b LICENSE NUMBER 000250	27c DATE SIGNED (Month Day Year) Feb. 6, 1989
28 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 21) (Type/Print) 4112 Columbia Ave - Muncie, IN SAMORLICH			
29 HEALTH OFFICER'S SIGNATURE E.A. Carragher, MD		29b DATE FILED (Month Day Year) 2-8-89	
30 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		31 DATE OF INJURY (Month Day Year)	32 TIME OF INJURY
33a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		33b INJURY AT WORK? (Yes or no)	
34 DESCRIBE HOW INJURY OCCURRED 000143		35 LOCATION (Street and Number or Rural Route Number, City or Town, State)	

